

## Mental Health Recovery in an In-Patient Setting

By Ken Braiterman

We started introducing WRAP at New Hampshire Hospital about three years ago. Acceptance by the medical staff has grown steadily, and they recommend it to patients. However, part of our agreement with the hospital is that WRAP can never be REQUIRED. I think our group is the only voluntary group the hospital offers. Recovery must be a free, personal choice, or it's not recovery.

We offer two groups: Another consumer and I focus on WRAP principles on Tuesdays, and two members of the rec therapy staff, who were trained in Brattleboro, help individuals with their personal WRAP plans on Thursdays.

Our Tuesday groups change constantly because it is a short-term hospital for most people. We never know on a given day how many people we'll have, and how many will be attending for the first time, or have attended many times. There was no way, within the hospital structure, to create a group that could meet regularly for 8 to 12 weeks, and this was our biggest challenge as facilitators. It means we have to arrive each week with a pocketful of contingency plans instead of a fixed agenda. Often, this means seeing who comes, where they're at that day, and moving from there to a discussion of whatever principle interests them. But we also have a topic every week we're prepared to discuss in case the group does not guide us. Sometimes we practice one or two wellness tools in the hour, especially ones they can use while they are inpatients. Other times, when we haven't done it for a while, we'll just list wellness tools they have used ! or might use someday. And every few weeks, when the group membership has turned over, we'll explain and make lists of triggers, early warning signs, and wellness tools for those.

We feel it's our responsibility to make sure that the person attending for the first time, the person who attends only once, and the people who attend many times all get something they can use every Tuesday. The group's confidentiality agreement -- which we insisted that the hospital agree to -- says that nothing anyone says here will be reported to anyone's treatment team (unless it's a threat to oneself or others). So we sometimes have to give people a little space to whine and cheese about their treatment and relationships with the staff and institution. We try to limit that and turn it as quickly as possible to positive discussions about self-advocacy that can apply to everybody.

We always ask who is here for the first time -- that's all we ask, not anything biographical or diagnostic. Then we ask someone who has been there a lot to explain what the group is about. If no one volunteers, we do that ourselves. It's about getting well and staying well, not being sick or fixing what's wrong with you. It's about mobilizing your strengths and assets to become the person you want to be, have the life you choose, and achieve the goals you choose.

The recovery principles my group is most interested in are "relapse prevention" -- daily maintenance, recognizing and reacting quickly to triggers and early warning signs, also post-crisis planning. Often, people are so focused on getting out that they give too little thought about what they're going to do when they get out, and how they're going to stay out. Everybody is focused on getting out, including people who know they'll have to stay a long time.

Self-advocacy is a big issue because so many inpatients don't know how to negotiate and are convinced they won't be listened to (a self-fulfilling idea). They go about it in a way guaranteed to increase their frustration level. Since many of these people are negotiating discharge conditions or treatment plans, learning to do it right is very interesting and important to them. We find that people can grasp the notion of framing solutions where they get what they want without someone else having to lose (win-win), and that developing mutual trust often requires incremental steps.

Another frequent topic is personal responsibility -- getting well is a choice that often starts when you stop playing the blame game, which keeps you from moving forward with your life even though those horrible people, and the horrible illness, really did do those horrible things to you. Those horrible things are not your fault, but it's your choice what you do next.

We don't usually get people who are truly without hope in our group. Coming to the group requires a certain measure of hope, or highly skeptical willingness to try something new even though nothing has ever helped before. I'm reminded here that we haven't talked with the group lately about how hope itself is a choice, not a feeling you either have or don't have, and can't control. When you're at rock bottom (and this is why you need consumers to talk about this with credibility) hope is the decision that living is better than dying, and you will postpone the decision to die until the death impulse passes. After a while, you come to realize that the death impulse always passes eventually, and you learn all kinds of ways to keep yourself alive until it does. Lately, the people in our group have been in a better place, and don't need to talk about this.

I've probably told you more than you want to know. The hospital pays us each \$50 per hour, which is more a matter of dignity and self-respect than money for us. They wouldn't ask any other consultant to share experience and expertise for nothing. In the group, we don't mention medicines by name because what's bothering you might be helping someone else. We avoid clinical language as much as possible. We don't go into much detail about people's personal trauma histories, but focus of feelings, symptoms and behavior instead. We never call a feeling a symptom and often correct group members who do. "No. You have a probate hearing in two days. This is not an anxiety attack. Your feelings are appropriate and you're handling them well." We don't comment on individual treatment plans or medication routines but encourage people to assert themselves with their treatment teams the right way, and keep at it until their! questions are answered and their concerns addressed.

Mary Ellen Copeland and her staff cannot address personal mental health problems and issues. We care very much about your concerns but we must focus our efforts on education and resource development. For more information on how to get help for yourself or the people you are supporting, please use the resources on this website.

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